SUPREME COURT, U.S.
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No. 09-1158

In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, ET AL., PETITIONERS,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENTS CALIFORNIA PHARMACISTS ASSOCIATION, CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, CALIFORNIA HOSPITAL ASSOCIATION, CALIFORNIA ASSOCIATION FOR ADULT DAY SERVICES, MARIN APOTHECARY, INC., SOUTH SACRAMENTO PHARMACY, FARMACIA REMEDIOS, INC., ACACIA ADULT DAY SERVICES, SHARP MEMORIAL HOSPITAL, GROSSMONT HOSPITAL CORPORATION, SHARP CHULA VISTA MEDICAL CENTER, SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER, FE GARCIA AND CHARLES GALLAGHER IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law.

2. Whether a state law reducing Medicaid reimbursement rates is preempted by 42 U.S.C. § 1396a(a)(30)(A).

PARTIES TO THE PROCEEDING

Petitioners identify (Pet. iii) all 15 of the plaintiffs named in the complaint in the district court action as the *California Pharmacists* respondents. It appears, however, that the California Pharmacists Association, California Medical Association, California Dental Association, Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy, South Sacramento Pharmacy, and Farmacia Remedios, Inc. were not parties in either of the court of appeals' proceedings arising from that action for which review is sought, and thus would not be respondents under Rule 12.6.

To the extent that they are respondents, however, they have consented to the filing of this brief on their behalf. Thus, the following discussion is only for purposes of accuracy.

The reason those six named plaintiffs are likely not respondents is that not all of the plaintiffs were appellants or appellees in the court of appeals in the appeals from the grant and denial of preliminary injunctions.

Plaintiffs California Medical Association and California Dental Association did not seek any preliminary relief and thus could not have been appellants or appellees.

PARTIES TO THE PROCEEDING—Continued

Five of the named plaintiffs (California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, and Sharp Coronado Hospital and Healthcare Center) sought a preliminary injunction regarding rates for hospitals. Dt. Ct. Dkt. 16. The preliminary injunction was denied, and they filed a notice of appeal. Dt. Ct. Dkt. 41.

The other eight named plaintiffs sought a single preliminary injunction in the district court regarding rate cuts for pharmacies and adult day health care centers. Dt. Ct. Dkt. 13. The preliminary injunction was denied for pharmacies, Pet. App. 86a-87a, and no one appealed that denial. The preliminary injunction was granted as to adult day health care centers, Pet. App. 104a, and petitioners appealed that preliminary injunction. Although petitioners did not identify who the appellees were in that appeal, it seems that the only appropriate appellees would have been the four plaintiffs who benefitted from that order, *i.e.*, plaintiffs Acacia Adult Day Services, the California Association for Adult Day Services, and Fe Garcia (incorrectly listed on the captions as Fey Garcia) and Charles Gallagher (individuals who received services at adult day health care centers), and not those four plaintiffs who were interested only in the pharmacy cuts, *i.e.*, California Pharmacists Association, Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy, South Sacramento Pharmacy, and Farmacia Remedios, Inc.

CORPORATE DISCLOSURE

The non-individual respondents that appear on the cover have no parent corporations and no publicly held company owns any stock in these respondents.

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INTRODUCTION

This is a tag-along petition filed by petitioners in an attempt to bolster their contention that the court of appeals' decision in *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (2008), cert. denied, 129 S. Ct. 2828 (2009), on further proceedings, 572 F.3d 644 (2009), petition for cert. pending, No. 09-958, is resulting in repeated judicial intervention in state Medicaid decisions both within the circuit and nationwide. It has no independent significance.

On March 24, 2010, the Court invited the Solicitor General to file a brief expressing the views of the United States in No. 09-958. No similar invitation is warranted in this case, and there is no need to hold this petition pending the filing of the federal government's brief. That is because the judgment in this case can be affirmed on bases unrelated to the procedural violations of Section 1396a(a)(30)(A), which is the basis of petitioners' challenge, or the enforcement of the Medicaid Act's preemptive effect through the Supremacy Clause.

STATEMENT

A. Statutory Framework

1. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid Act"), is a cooperative federal-state program that provides federal financial assistance to participating States to enable them to provide medical treatment for the poor, elderly, and disabled. A State's participation in Medicaid is

voluntary. To receive federal funds, however, States are required to establish and administer their Medicaid programs through individual "State plans for medical assistance" approved by the federal Secretary of Health and Human Services (HHS). 42 U.S.C. § 1396. In response to the current economic crisis, the federal government currently pays California approximately $3.10 for every $2 the State spends through its plan. 75 Fed. Reg. 5,325, 5,326 (Feb. 2, 2010).

When a State desires to change its existing plan, it must submit a plan amendment to HHS. HHS has 90 days to make a determination whether the amendment complies with the Medicaid Act. 42 U.S.C. § 1396n(f)(2). If HHS does not act within this time frame, the state plan amendment is considered approved. *Ibid.* If, however, HHS asks for more information from the State, HHS has a second 90-day time frame within which to approve or disapprove the amendment, beginning on the date the requested information is received from the State. *Ibid.* A State is not permitted to implement a plan change until it receives federal approval. *Exeter Mem. Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998); 42 C.F.R. § 430.20(b)(2) (incorporating Section 447.256(a)(2), which incorporates Section 447.253(i), which provides that the state "Medicaid agency must pay for * * * services using rates determined in accordance with methods and standards specified in an approved State plan").

The Medicaid Act provides specific requirements for state plans and reimbursement rates. Section 1396a(a)(30)(A), the provision at issue in this case, provides that a state plan

> must * * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary [1] to safeguard against unnecessary utilization of such care and services and [2] to assure that payments are consistent with efficiency, economy, and quality of care and [3] are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (bracketed numbers added).

This case involves the requirements of Section 1396a(a)(30)(A) that mandate that a state plan establish payment rates for medical care and services available under the plan that are both consistent with quality medical care (the "quality of care" provision) and sufficient to enlist enough providers to ensure that medical care and services are as available to recipients as is generally available to the public in the same geographical area (the "equal access" or "enough providers" provision).

2. The Legislature enacted Assembly Bill 1183 ("AB 1183"), on September 30, 2008. Pet. App.

198a-217a. Section 45 of AB 1183 added a new Section 14105.191 that, effective March 1, 2009, required a five percent rate cut for certain Medi-Cal fee-for-service payments and benefits, including adult day health care centers (ADHCs) and certain hospital services, and a one percent rate reduction for all other fee-for-service benefits (including hospital outpatient services). Pet. App. 205a-210a.

Contrary to petitioners' claim (Pet. 9, 36), nothing in AB 1183 gave petitioners discretion in determining whether or not to implement the rate cuts adopted by the statute. To the contrary, AB 1183 provides that "the director *shall* reduce provider payments, as specified in this section" "[n]otwithstanding any other provision of law." Pet. App. 205a.[1]

B. Factual Background

1. Respondents are comprised of three sets of plaintiffs who brought three separate actions. The respondents filing this brief are various Medi-Cal providers (including hospitals and ADHCs), associations representing those providers, and two individuals who receive Medi-Cal services.

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[1] Both the district court and court of appeals held that petitioners retained no discretion under state law to decline to implement the rate cuts even if they violated federal requirements. Pet. App. 23a-28a, 97a. Petitioners have not sought to show that the lower courts' reading of the statute is "'plain' error," *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 500 n.9 (1985), as they would be required to do to overturn that reading of the state statute.

Petitioners are various California officials in their official capacities. Petitioner Maxwell-Jolly, the Director of the California Department of Health Care Services, was sued by all respondents in all three actions. Additional state officials were sued by only one set of plaintiffs in one of the other actions. Yet, for ease of reference, this opposition refers to petitioners in the plural even when discussing solely the action brought by these respondents.

On January 29, 2009, respondents sued petitioners, to prevent the implementation of AB 1183. Respondents alleged, inter alia, that the actions of petitioners to implement the five-percent and one-percent payment reductions of AB 1183 were pre-empted under the Supremacy Clause by Section 1396a(a)(30)(A).

a. The district court granted respondents' motion for a preliminary injunction as applied to ADHCs. Pet. App. 84a-105a. ADHCs provide an alternative to institutional care, responding to the State's need "to establish and to continue a community-based system of quality adult day health care which will enable elderly persons or adults with disabilities to maintain maximum independence." Cal. Health & Safety Code § 1570.2.

The district court found that, over ten years earlier, the court of appeals' decision in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998), had established that Section 1396a(a)(30)(A) required that "when the State

of California seeks to modify reimbursement rates for health care services provided under Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors." Pet. App. 95a.

The district court found that respondents had established a "strong likelihood of success on the merits" because it "appears that the Legislature * * * did not properly consider relevant factors prior to the passage of the five percent rate reduction in AB 1183." Pet. App. 99a. In particular, the district court found that while there was evidence that the Legislature discussed and modified the rate reductions in various respects, "none of this demonstrates that the Legislature relied on responsible cost studies providing reliable data in setting the rates." Pet. App. 98a-99a.

The district court also rejected petitioners' claim that their performance of a post-enactment analysis met the requirements of Section 1396a(a)(30)(A). First, the district court determined that petitioners did not have "any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors." Pet. App. 97a. Because the Department had "no authority to alter the rate reduction," it was not the "body responsible for rate setting" that was required to "consider the relevant factors." Pet. App. 98a. Moreover, the district court was "not persuaded that the analysis actually conducted by the Department was adequate" because it relied on an

inadequate proxy to measure ADHC costs. Pet. App. 99a.

The district court also found respondents had established irreparable injury to Medi-Cal beneficiaries due to the proposed rate cuts because they would be "at risk of losing access to ADHC services." Pet. App. 102a. That, in turn, created a "significant threat to the health of Medi-Cal recipients." Pet. App. 103a.

The balance of hardships and public interest also weighed in favor of a preliminary injunction, the district court found, because the proposed cuts might not save the State any money because "many Medi-Cal beneficiaries may turn to more costly forms of medical care, such as emergency room care." Pet. App. 103a n.7. In addition, the court noted, its injunction did not prevent the State from deciding "to implement a rate change upon making a properly reasoned and supported analysis." Pet. App. 104a.

No motion to stay the injunction was filed.

b. In a separate order, the district court denied respondents' motion for a preliminary injunction as applied to hospitals. Pet. App. 106a-127a. As with the ADHCs, the district court found that respondents had established a strong likelihood of success on the merits because the Legislature did not consider any of the relevant factors before it enacted AB 1183. Pet. App. 119a-120a. For this reason, it did not reach respondents' alternative argument that AB 1183 was preempted because it was implemented

without approval from the federal government. Pet. App. 120a n.9.

The district court found, however, that respondents did not establish that Medi-Cal beneficiaries "will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions." Pet. App. 126a.

2. Petitioners appealed the grant of the preliminary injunction regarding ADHCs and respondents appealed the denial of the preliminary injunction regarding hospitals.

a. Without objection from petitioners, the appeals were assigned to a panel that previously had addressed preliminary injunction appeals involving Medi-Cal.

While briefing was on-going, petitioners sought to vacate the panel's opinion in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009), petition for cert. pending, No. 09-958, on the ground that the appeal and cross-appeal in that case were moot when the panel issued its opinion. The panel denied that motion, finding that the appeals were not moot. *See* 590 F.3d 725 (9th Cir. 2009). In doing so, the panel found that the Attorney General had engaged in "a clear violation of Rule 5-200" of the California Rules of Professional Conduct, which prohibits members of the bar from misleading the judiciary through any false statement, and noted that the Attorney General's conduct gave the panel "pause about accepting the

veracity of future pleadings filed by the Attorney General on behalf of the Director, if not more generally." *Id.* at 730.

Petitioners then moved to recuse the judges of that panel from sitting on this appeal. The panel denied the motion on January 15, 2010. It explained that the Attorney General had "misled the court" in the prior case and "having been less than truthful once before, the Attorney General is in no position to question this panel's impartiality for simply calling him to account for his lack of candor." 09-55532 C.A. Order at 5-6 (Jan. 15, 2010). The panel concluded that the Attorney General "may rest assured that he will receive fair and unbiased treatment from the court, as will all other litigators who are willing to comply with the rules that govern their professional conduct as well as the applicable rules of court." *Id.* at 6.

b. The court of appeals affirmed the district court's entry of a preliminary injunction regarding the rate cut as applied to ADHCs. Pet. App. 1a-36a.

The court of appeals confirmed that "if the legislature elects to by-pass the Department and set the rates itself, it must engage in the same principled analysis [the court of appeals] required of the Director in" *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998). Pet. App. 13a-14a. It expressly noted that it was "not telling the State something new," and that its holding was apparent in earlier decisions. Pet. App. 15a. It

also was "consistent with that of [other] circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services *before* enacting rates." Pet. App. 15a-16a.

The court of appeals "emphasize[d] that the State need not follow 'any prescribed method of analyzing and considering the [Section 1396a(a)(30)(A)] factors," but that Congress intended that the decisionmaker engage in some "study [of] the impact of the contemplated rate change on the statutory factors *prior to* setting rates." Pet. App. 17a. The court of appeals further held that the district court did not commit clear error in finding that the legislature did not adequately consider the Section 1396a(a)(30)(A) factors before enacting AB 1183, Pet. App. 17a-21a, but was concerned "solely with budgetary matters," Pet. App. 20a, which contravened *Orthopaedic's* holding that "purely budgetary concerns" were not a sufficient ground for setting rates. 103 F.3d at 1498-1499 & n.3.

In addition, the court of appeals held that, as a matter of state law, petitioners did not have discretion not to implement the legislatively-set rates and thus any post-enactment study was not the meaningful consideration required by Section 1396a(a)(30)(A). Pet. App. 23a-28a nn.3-5. In the alternative, it held that even if petitioners did have that authority, the district court did not clearly err in holding that

petitioners' analysis was inadequate because it looked to the average costs of only six nursing facilities, with widely varying costs, as a proxy for the 313 ADHCs in the Medi-Cal program. Pet. App. 29a. Respondents provided evidence showing that there was no basis for equating the costs of these six facilities with ADHCs, which provide a completely different range of services. Pet. App. 100a n.6. Petitioners were forced to rely on this inadequate proxy because, despite a statute enacted in 2006 that required it to establish a cost-based system by 2010, Cal. Welf. & Inst. Code § 14571.2(f), it had just begun the process of auditing ADHC costs, Pet. App. 29a.

As another alternative for sustaining the district court's preliminary injunction, the court of appeals held that if compliance with Section 1396a(a)(30)(A) was judged solely based on substantive compliance with the "enough providers" provision, it "would find that violation here" because petitioners "concede[] that here, the evidence indicates that at least some ADHC Medi-Cal providers would stop treating beneficiaries due to AB 1183." Pet. App. 33a.

The court of appeals also held that the district court did not clearly err in finding irreparable injury nor abuse its discretion in determining the balance of equities or the public interest. Pet. App. 34a-35a.

c. The court of appeals reversed the district court's denial of a preliminary injunction regarding the rate cut as applied to hospitals. Pet. App. 37a-41a. The court of appeals agreed with the district court's

determination of respondents' likelihood of success on the merits for all the reasons the appellate court articulated for ADHCs. Pet. App. 40a. The court of appeals determined, however, that the district court had abused its discretion in finding a lack of irreparable injury. Respondents had shown that they were being reimbursed less than the amount to which they otherwise were entitled and that they would not be able to recover those payments from petitioners in light of the State's Eleventh Amendment immunity. Pet. App. 38a-40a.[2]

3. Petitioners did not move to stay the mandates, both of which issued on March 25, 2010.

On remand, the district court denied petitioners' oral motion to stay the action. Dt. Ct. Dkt. 83 at 1. The parties agreed to engage in discovery and then file dispositive motions on a permanent injunction on or before February 28, 2011. Dt. Ct. Dkt. 80 at 3. The parties represented that they "anticipate that the matter will be resolved by dispositive motions." *Ibid.*

REASONS THE PETITION SHOULD BE DENIED

As with petitioners' other pending petition for certiorari in No. 09-958, the questions raised by petitioners from these preliminary injunction cases do

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[2] The court of appeals had earlier granted a stay of the rate cut pending appeal. Pet. App. 42a-51a. The court of appeals denied petitioner's petition for rehearing en banc without recorded dissent. Pet. App. 52a.

not warrant this Court's review and, even if they did, these cases are not appropriate vehicles to address them.

Petitioners assert (Pet. 28) that the decisions of the court below involve an issue of national importance. But California has been alone in demonstrating a plain disregard for the rate-setting requirements embodied in the Medicaid Act. Instead of engaging in a reasoned analysis before enacting cuts in its payments to providers of medical and other essential services to Medicaid recipients, California sought to cut payments by arbitrary amounts without regard to the likely impact of those cuts and irrespective of costs. No court in the 45-year history of the Medicaid Act program has interpreted the Act to allow wholly budget-driven reductions to Medicaid rates without consideration of the effect of the reductions on "efficiency, economy, and quality of care," or whether the reduced rates were sufficient "to enlist enough providers so that care and services are available" to eligible individuals. 42 U.S.C. § 1396a(a)(30)(A). Consequently, the vast majority of cases where injunctions have been granted relating to Medicaid reimbursement have been in California.

This focus on California also reflects the fact that, even before its current attempts to cut rates, California's payments per enrollee were the nation's lowest for adults, and second lowest in the nation for all enrollees. The Kaiser Family Foundation, *Medicaid Payments per Enrollee, FY2006, available at* http://www.statehealthfacts.org/comparetable.jsp?ind=

183&cat=4 (last visited May 20, 2010). California's payments per enrollee in 2006 were less than 60% of the national average. *Ibid.*

Petitioners have identified only three injunctions entered in the past 21 months against States other than California—those cases involved two temporary restraining orders followed by mootness or settlement and one stipulated permanent injunction. Pet. App. 237a-242a. And, although petitioners do not trumpet the fact, the court of appeals below also has rejected efforts to obtain injunctive relief in cases raising similar claims when the facts did not establish a need for immediate intervention. *See National Ass'n of Chain Drug Stores v. Schwarzenegger*, No. 09-57051, 2010 WL 1506928 (9th Cir. Apr. 15, 2010) (affirming denial of preliminary injunction); *Carter v. Gregoire*, No. 09-35755, 2010 WL 235264 (9th Cir. Jan. 20, 2010) (same). This is hardly evidence of judicial overreaching.

Thus, while petitioners are correct that lawsuits have been filed seeking relief under the Supremacy Clause (although it is unclear whether such suits are being filed at any greater rate than in previous years), the results of those suits demonstrate that States that follow the mandates of federal Medicaid law will not suffer budgetary "catastrophes" as a result of the preemption holding of the court below. Instead, the courts are playing their traditional role as a last line of defense against arbitrary and unreasoned state conduct that conflicts with federal law.

I. THESE CASES ARE NOT APPROPRIATE VEHICLES TO ADDRESS PETITIONERS' CLAIMS

A. Review Of The First Question Presented Is Unwarranted Because The Court's Resolution Would Not Affect The Authority Of The District Court To Entertain Respondents' Preemption Claim

This case is not an appropriate vehicle to resolve the first question presented by petitioners—namely, whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law—because the Court's resolution of that question would not affect the authority of courts to entertain respondents' claims. In California, a well-established state cause of action provides respondents a method for raising the same preemption claim. This Court has denied review in comparable circumstances where the resolution of the question presented "could not change the result reached below, since petitioner[s] would be liable under either federal or state law." Eugene Gressman, *et al.*, *Supreme Court Practice* 248 (9th ed. 2007).

California law provides a cause of action in which a party injured by a state official's failure to comply with federal law may sue for a writ of mandamus to compel that state official to act. Well before the court of appeals' decisions below, the state courts made clear that this state cause of action does not require

the showing that the federal statute secures a "right," as that term has developed its meaning under 42 U.S.C. § 1983, but only a showing that the plaintiff is "beneficially interested" in compliance with the federal law. *California Homeless & Housing Coalition v. Anderson*, 31 Cal.App.4th 450, 458 (1995); *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App.4th 891, 896 (1999); *California Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696, 706 (2007); *Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 168 Cal.App.4th 460 (2008), rev. denied (Cal. 2009). Indeed, that state cause of action has been used to enforce the very statutory provision—Section 1396a(a)(30)(A)—that respondents have demonstrated petitioners violated in these cases. *See, e.g., California Ass'n of Health Facilities v. Department of Health Servs.*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006).

Although this state cause of action was not the basis for the interlocutory rulings of the court below, this Court does not generally grant review unless a reversal would change the position of the parties in some concrete fashion. *See The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 183 (1959). Here, even if petitioners were to prevail on their first question presented, respondents could still pursue their claims through the state action, arguably in federal court because the claims would arise under federal law. *See* Pet. Mem. in Opp. to Mot. to Remand at 5-6, 8-9, *California Medical Ass'n v. Shewry*, No. 08-03363 (C.D. Cal. June 9, 2008) (argument by petitioners

that state mandamus action to enforce federal Medicaid Act arises under federal law pursuant to *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308 (2005)); Pet. Mem. in Opp. to Mot. for Remand at 3-6, *California Health Ass'n v. Shewry*, No. 06-4027 (N.D. Cal. Aug. 14, 2006) (same).

B. Review Of The Second Question Presented Is Unwarranted Because The State Has Stalled The Federal Approval Process

As with the case at issue in No. 09-958, there is also a lurking contingency that makes this case a poor vehicle for this Court's review and, in this case, provides an alternative basis for affirmance even apart from Section 1396a(a)(30)(A).

As noted above, a State may not implement rate cuts until HHS approves an amendment to the state plan. *See* page 2, *supra*. Petitioners' proposed state plan amendment reflecting AB 1183's changes has not been approved by HHS. That failure of petitioners to get approval was one of the grounds pressed by respondents for obtaining the injunction in both the district court and the court of appeals, although it was not reached by either court. Pet. App. 120a n.9; 09-55365 Resp. C.A. Br. 39.

Instead of obtaining approval, petitioners have stalled the entire approval process. On September 30, 2008, petitioners submitted their state plan

amendment to HHS. Pet. 9.[3] Petitioners explained to HHS that the state plan amendment it submitted for approval would "provide authority for the * * * payment reductions to specified providers and programs."

In December 2008, HHS responded with a nine-page request for additional information. App., *infra*, 1a-20a. With regard to compliance with Section 1396a(a)(30)(A), HHS explained that the state plan amendment that was submitted "is inadequate and does not provide sufficient information to understand the reimbursement methodology." App., *infra*, 8a. HHS asked petitioners to explain "[w]hat impact, if any, does this proposed [state plan amendment] have on access to providers providing these non-institutional services in California?" App., *infra*, 9a.

That HHS letter concluded by explaining that the request for additional information "has the effect of stopping the 90-day clock with respect to [HHS] taking further action on this State plan submittal" and stating that a "new 90-day clock will not begin until we receive your response to this request for additional information." App., *infra*, 20a. Finally, the letter stated that "[i]n accordance with our guidelines to all State Medicaid Directors dated January [2], 2001, we request that you provide a formal response

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[3] As petitioners explain (Pet. 9 n.3), that state plan amendment was subsequently split into a number of separate plan amendments. The language quoted in the text, and the language drawn from HHS' response, was virtually identical for all of the state plan amendments.

to this request for additional information within ninety (90) days of receipt." *Ibid.*

It has now been 18 months since HHS sent that letter and respondents are informed by HHS that, as of March 30, 2010, petitioners still have not provided a formal response. App., *infra*, 24a. That alone is sufficient grounds for HHS to disapprove the proposed amendment.[4] Although petitioners claim (Pet. 37) that they have submitted some materials requested by HHS and are in "constant communication" with the agency, the fact is that the clock has stopped on HHS' processing of the amendment and, until the clock is restarted and the amendment is approved, the cuts should not take effect.

Indeed, according to a document from HHS, California currently is in default on multiple requests for additional information. App., *infra*, 23a-24a. This puts California's complaint that private litigation has usurped the role of HHS in a particularly poor light, given that California does not seem to want to be accountable to HHS (or anyone else) as to its compliance with the Medicaid Act, despite continuing to take billions of dollars in federal funds.

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[4] *See* Letter from Timothy Westmoreland, Director, Health Care Finance Administration, U.S. Dep't of Health & Human Servs., to State Medicaid Directors, at 1 (Jan. 2, 2001), *available at* http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf (last visited May 20, 2010).

II. CERTIORARI SHOULD BE DENIED ON THE FIRST QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

Every court of appeals is in accord with the holding of the court below that a federal court may resolve, on the merits, an action against a state official for injunctive relief alleging that a state law is preempted by a federal law.

Petitioners now avoid complaining of any conflict in the courts of appeals, but instead contend (Pet. 27 & n.10) that the fact that courts of appeals across the country all have reached the *same* result as the court below is a ground for this Court's review.[5] But that

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[5] In addition to the cases from the First, Fifth, Eighth, and D.C. Circuits cited by petitioners, decisions from the Second, Third, Fourth, Sixth, and Seventh Circuits likewise are in accord. *See Western Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225-226 (2d Cir. 1987), cert. denied, 485 U.S. 1006 (1988); *St. Thomas-St. John Hotel & Tourism Ass'n v. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Verizon Maryland, Inc. v. Global NAPS, Inc.*, 377 F.3d 355, 368-369 (4th Cir. 2004); *GTE North, Inc. v. Strand*, 209 F.3d 909, 916 (6th Cir.), cert. denied, 531 U.S. 957 (2000); *Illinois Ass'n of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002). Although petitioners have in the past questioned the governing rule in the Eleventh Circuit, the en banc decision in *BellSouth Telecommunications, Inc. v. MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270 (11th Cir. 2003) (en banc), reached

(Continued on following page)

overwhelming consensus in the courts of appeals is due to this Court's consistent sanctioning of such actions.[6]

Petitioners try to distinguish the decisions below from all the others on the ground that, they claim (Pet. 37-38), Congress purposefully amended the Medicaid Act to make Section 1396a(a)(30)(A) unenforceable by private parties. But that argument makes the decisions below even less worthy of review, as there is no split with any other court of appeals as to

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beyond any jurisdictional ruling and held that, apart from any express cause of action available under the relevant statute, "[f]ederal courts must resolve" on the merits "the question of whether a public service commission's order violates federal law." *Id.* at 1278 (citing *Verizon Maryland Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002)).

[6] *See* Richard H. Fallon, Jr., Daniel J. Meltzer & David L. Shapiro, *Hart & Wechsler's The Federal Courts & The Federal System* 903 (5th ed. 2003); 13D Charles A. Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3566 (3d ed. 2008); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting). Accepting petitioners' contrary view would call into question the propriety of many preemption cases brought against state officials in federal court, including a number that have been heard by this Court on the merits in the past few Terms, *see, e.g.*, *Cuomo v. Clearing House Ass'n, L.L.C.*, 129 S. Ct. 2710 (2009); *Chamber of Commerce of the United States v. Brown*, 128 S. Ct. 2408 (2008); *Rowe v. New Hampshire Motor Transport Ass'n*, 552 U.S. 364 (2008); *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1 (2007), including cases involving preemption under the Medicaid Act, *see Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006); *PhRMA v. Walsh*, 538 U.S. 644 (2003).

whether any portions of Section 1396a(a) may be enforced through the Supremacy Clause.

In any event, petitioners are wrong. As evidence of congressional intent, petitioners rely solely on the legislative history surrounding the 1997 repeal of a separate provision of the Medicaid Act, known as the Boren Amendment, previously codified at 42 U.S.C. § 1396a(a)(13)(A). Seven years before the Boren Amendment's repeal, this Court held that it was enforceable through 42 U.S.C. § 1983. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). But, when Congress apparently grew dissatisfied with that result, it did not eliminate the Section 1983 cause of action while preserving the Boren Amendment's substantive requirements. Instead, Congress simply repealed those specific substantive requirements that it no longer wished to be enforced. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507.

At the time of the Boren Amendment's repeal, however, Section 1396a(a)(30)(A) had consistently been held to impose an independent, enforceable requirement in establishing reimbursement standards for provider services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998); *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996), cert. denied, 519 U.S. 1114 (1997); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th

Cir. 1996); *Arkansas Med. Soc., Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).[7] The Boren Amendment's "repeal, like its enactment, modified § 13(A) alone; it effected no change to § 30(A)." *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-941 (9th Cir. 2005). Thus, petitioners' reliance on a snippet from a 1997 committee report discussing the repeal of the Boren Amendment that described the repeal as precluding enforcement by providers of "any other" provision of Section 1396a, H.R. Rep. No. 105-149, at 591 (1997), does not alter the fact that the text of Section 1396a(a)(30)(A) was not amended in 1997. That subsequent legislative history is thus irrelevant. *See Doe v. Chao*, 540 U.S. 614, 626-627 (2004).

III. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO RELEVANT DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THE MEDICAID ACT

Petitioners claim (Pet. 34) that the Ninth Circuit's interpretation of Section 1396a(a)(30)(A) makes

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[7] *See also Clark v. Kizer*, 758 F. Supp. 572, 578 (E.D. Cal. 1990), aff'd in relevant part, 967 F.2d 585 (9th Cir. 1992); *Illinois Hosp. Ass'n v. Ill. Dep't of Pub. Aid*, 576 F. Supp. 360, 368 (N.D.Ill.1983); *Daniel B. DeGregorio v. O'Bannon*, 500 F. Supp. 541 (E.D. Pa. 1980); *Opelika Nursing Home, Inc. v. Richardson*, 356 F. Supp. 1338, 1343 (M.D. Ala. 1973).

it an "outlier." But the court of appeals correctly held that the district court did not abuse its discretion in finding that respondents had established a likelihood of success on the merits of their claims sufficient to sustain a preliminary injunction.

The court of appeals "emphasize[d] that the State need not follow 'any prescribed method of analyzing and considering the [Section 1396a(a)(30)(A)] factors." Pet. App. 17a. And the court of appeals repeatedly has explained that under any interpretation (including that of other circuits or even that of petitioners themselves) California's across-the-board rate reductions—which were made solely for budgetary reasons; without any prior consideration of efficiency, economy, and quality of care; and which would create access and quality of care problems for beneficiaries—do not comply with the statute.

A. The Outcome Would Be The Same Under Petitioners' Proposed Interpretation Of The Statute

Because the court of appeals also held that petitioners did not satisfy Section 1396a(a)(30)(A)'s substantive requirements, the outcome in these cases would not change even if, as petitioners contend, the court erred in interpreting the provision as containing a procedural component.

Petitioners acknowledge that Section 1396a(a)(30)(A) contains substantive requirements, contending only that the provision "does not preclude a state from reducing rates to address a budgetary crisis, *so long*

as the substantive requirements of the statute are met." Pet. 31 (emphasis added). Indeed, petitioners have previously argued to this Court that Section 1396a(a)(30)(A) "sets some substantive objecti[ves]," including that the rates cannot be so low "as to create an access or quality of care problem for beneficiaries." 09-958 Pet. 33, 26.[8]

The court of appeals squarely held in the decision below that even if compliance with Section 1396a(a)(30)(A) was judged solely based on substantive requirements, it "would find that violation here." Pet. App. 33a. Similar findings were affirmed in the other appellate cases that petitioners combined in this petition, albeit sometimes phrased in terms of irreparable injury. Pet. App. 40a, 57a, 81a-82a.

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[8] The history of Section 1396a(a)(30)(A) confirms petitioners' acknowledgement that the provision's requirement that rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" is a substantive obligation. In the public law that added this language, Congress entitled this amendment: "Codification of adequate payment level provisions." Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260 (1989). The legislative history confirms that this requirement (which previously existed as an agency regulation) was added to Section 1396a(a)(30)(A) because Congress was concerned that States were setting rates too low to attract providers. "[W]ithout adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." H.R. Rep. No. 101-247, at 389-390 (1989).

Petitioners do not challenge this finding. Accordingly, review of the court of appeals' alternative holdings is not warranted, as it would not affect the merits judgment below.

B. The Court Of Appeals Has Provided Clear Notice To Petitioners Of Its Consistent Textually-Rooted Interpretation Of Section 1396a(a)(30)(A) And Petitioners Retain The Option Of Submitting Additional Evidence At The Permanent Injunction Stage

1. Claiming that the court of appeals continually moves the goal posts, petitioners argue that the decisions below add new, unanticipated wrinkles to complying with Section 1396a(a)(30)(A). That is incorrect. The court of appeals' interpretation of Section 1396a(a)(30)(A) has remained constant, and consistent with its text, since the court decided *Orthopaedic* over 13 years ago. The *Dominguez* respondents in their brief in opposition document all the errors in the petitioners' description of the court of appeals' holding. This opposition briefly focuses on the broader picture.

The decision in *Orthopaedic* made clear that the State had an obligation to perform its analysis of the Section 1396a(a)(30)(A) factors *before* the enactment of rate reductions. In that case, the state agency had implemented an increase in rates for certain services, but the plaintiffs argued that the agency had not considered the factors required by Section 1396a(a)(30)(A) and, by failing to do so, had provided

too little in terms of increases. The court of appeals agreed. It specifically rejected the agency's reliance on a study performed after it had set the rates. The court held that because the agency "did not consider hospitals' costs *when* reevaluating its rates, it has not appropriately applied § 1396a(a)(30)(A)." 103 F.3d at 1500 (emphasis added).

Likewise, *Orthopaedic* was clear that the entity that set the rates was the one that had to consider the relevant factors, because one "cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services." *Id.* at 1496. Although the appeal in that case did not involve legislatively-set rates, such rates were challenged in the district court in that case, and the district court made clear that such rates would comply with Section 1396a(a)(30)(A) only if "the legislature in enacting the statute had expressly considered 'efficiency, economy, and quality of care.'" *Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 WL 345652, at *9 (C.D. Cal. Oct. 5, 1992). Thus, as the court of appeals here correctly observed, it was "not telling the State something new" in these decisions. Pet. App. 15a.

2. Finally, petitioners disregard the fact that the decisions below addressed interlocutory orders regarding preliminary injunctions, and that petitioners are free to raise their claims of error with the district court after full discovery and briefing. So to the extent they believe the courts below overlooked or

misunderstood the facts, petitioners will have another chance to make their case.

If petitioners succeed in the district court in defeating entry of permanent injunctions, then petitioners will have prevailed without regard to the decisions in these interlocutory opinions. That is precisely the position petitioners currently are taking in the district court against the respondents filing this opposition, where the petitioners intend to take discovery and file for summary judgment. Dt. Ct. Dkt. 80 at 3. It is because "many orders made in the progress of a suit become quite unimportant by reason of the final result, or of intervening matters," *American Constr. Co. v. Jacksonville, T. & K. W. Ry. Co.*, 148 U.S. 372, 384 (1893), that this Court has held that the interlocutory posture of a decision "alone furnishe[s] sufficient ground" for denying review. *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916). That is true here.

CONCLUSION

The petition for a writ of certiorari should be denied.

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